DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155238	A. BUILDING _____ B. WING _____	C 12/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - VANCEBURG	88 EASTHAM STREET VANCEBURG, KY 41179

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey investigating ARO KY00015656 was conducted 12/01/10 through 12/02/10 and was substantiated. Immediate Jeopardy was identified on 12/02/10 and was determined to exist on 11/19/10, and was ongoing. Deficiencies were cited at CFR 483.25 Quality of Care, F323 at a Scope and Severity (S/S) of a "J." Substandard Quality of Care was identified at CFR 483.25 F323. An acceptable Allegation of Compliance was received on 12/07/10. A Partial Extended Survey was conducted 12/06/10 through 12/07/10. The Immediate Jeopardy was determined to be removed on 12/03/10.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements. **#1- Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice:** **Resident #1: Upon return to the facility, the Charge Nurse performed a complete physical assessment with no noted injuries, and vital signs were at baseline for Resident #1.**	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure residents who had been assessed by the facility as being at risk for wandering and/or exit seeking behaviors received adequate supervision for one (1) of six (6) sampled residents (Resident #1), of the twelve (12) residents the facility had assessed as being at risk.	F 323	**The family and physician were notified by the charge nurse. No new orders were given from the physician/Medical Director for revisions to current plan of care.** **The resident was placed on every fifteen minute observation checks. Since the time of the event, there have been no further attempts to exit with the 15 minute visual checks in place. The 15 minute visual check is a new intervention post the event, and has been effective since implementation. Prior to the event, resident was not on 15 minute visual checks. In addition to the 15 minute visual checks, additional measures were immediately implemented on 11/19/10 for resident #1's plan of care by the Director of Nursing and communicated to the charge nurses. The new interventions included distraction techniques such as books and magazines, snacks provided prior to meals,**	

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BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Barkley — TITLE: Executive Director — (X6) DATE: 12-17-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 Resident #1 exited the facility, without staff knowledge, on 11/19/10, and was found beyond the back parking lot in a grassy area near a highway. The temperature was forty-eight (48) degrees when the resident exited the facility. The failure of the facility to provide adequate supervision for residents at risk for elopement placed residents in the facility at risk for serious harm, injury, impairment or death. The findings include: Based on record review, it was revealed Resident #1 was admitted to the facility on 06/30/06 with diagnoses which included Alzheimer's Disease. Review of the 09/24/10 quarterly Minimum Data Set (MDS) assessment revealed the facility assessed Resident #1 as having both short and long-term memory problems and moderately impaired cognitive skills for daily decision making. The facility assessed Resident #1 as being at risk for elopement, and an elopement safety bracelet was implemented on 01/06/06. A review of Resident #1's care plan, dated 11/13/10 revealed interventions including an elopement safety bracelet, redirection of Resident #1 from exit doors, and involving the resident in preferred activities. The care plan was updated on 11/19/10, following the elopement, to include every fifteen (15) minutes checks, and snacks throughout the day and evening. Review of the "Verification of Investigation Report" dated 11/19/10, and an investigation summary dated 11/24/10, revealed Resident #1 exited the facility on 11/19/10, between 5:20 PM and 5:30 PM, and was found outside the facility at	F 323	encourage church after supper and a bed time snack. In addition to the every 15 minute visual checks, there are multiple staff interactions with the resident throughout the day/shifts to include, but not limited to activities of daily living including bathing, 3 meals and snacks daily, assistance with toileting needs, medication passes, and staff other than nursing that have interactions/visual exposure to Resident #1 such as housekeeping, maintenance, social services, recreation, etc, as well as daily family visits. Also on 11/19/10, the resident's Secure Care Bracelet was checked against all secure locking doors by the charge nurse on duty to ensure that the alarm working effectively and found no issues noted during this check. In addition, once change of shift occurred, the on-coming charge nurse also performed door checks on 11/19/10 on every door and found that the door alarms were functioning correctly. On 11/19/10, staff interviews were conducted by the Director of Nursing verbally by phone with staff that were currently on duty related to alarm system, asking when they last saw resident, did they hear an alarm, did they silence an alarm, was the resident assessed upon re-entering the facility, were the doors checked. From these interviews, it was determined Resident #1 had been seen within 10 minutes prior to being returned to the facility. It was determined the alarm was heard upon re-entering the facility but not on exit. The resident's attending physician, which is the facility Medical Director, was made	

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F 323	Continued From page 2 5:30 PM. Interview with Certified Nursing Assistant (CNA) #3, on 12/01/10 at 3:17 PM, revealed Resident #1's behavior was "normal" on 11/19/10, and the resident had mentioned wanting to go home. The CNA stated she would redirect Resident #1 by encouraging him/her to take a break from work and have a snack. According to CNA #3 the facility had the fire doors closed on 11/19/10, and she was unable to closely monitor residents on the unit. The CNA stated she last observed Resident #1 on the 300 Unit hallway at 5:20 PM on 11/19/10. The CNA did not hear any alarms prior to the resident being returned to the facility, but did hear the front door alarm when the resident was returned to the facility. The CNA thought any sounding alarm could have been muffled by the closed fire doors and other noise on the unit. Interview with CNA #7, on 12/02/10 at 11:45 AM, revealed she was assigned to provide care for Resident #1 on 11/19/10. The CNA stated she observed Resident #1 on the 300 Unit, near the nurse's station at 5:20 PM. The CNA stated she spoke with the resident at that time, and had looked at her watch when she spoke with the resident. CNA #7 stated the resident was wearing a hat, sweater, shoes, pants and a grey sweater coat. CNA #7 explained that Resident #1 was behaving as usual, thought he/she was an employee of the facility, and had work to do. Interview with Licensed Practical Nurse (LPN) #1, on 12/01/10 at 2:30 PM, revealed she, or other staff, would usually check on Resident #1 every few minutes. She described Resident #1 as "pretty hard to miss" in his/her Merri-Walker.	F 323	aware of this event of resident #1. Through the facility thorough investigation they were unable to be determined which door the resident had exited. On 11/20/10, an ad hoc Quality Assurance and Assessment meeting was initiated with the Director of Nursing, Executive Director, Medical Director and 2 charge nurses to address action items for follow-up on the elopement event. On 12/02/10, Resident #1 reassessed for additional measures for elopement prevention. On 12/02/10, a second Secure Care Bracelet was placed on Resident #1's Merry Walker by the Director of Nursing after assuring functioning with hand-held transmitter and checking expiration date. This is in addition to the secure care bracelet already in place on ankle of Resident #1. The care plan for Resident #1 was updated by the Director of Nursing on 12/02/10 to reflect the new interventions. Specific interventions for the list of affected residents as identified in the 2567 correspondence addressed in #2 bullet following. Please note that of the 12 identified residents (#1,2,3,5,7,8,9,10,11,12,13,14), #12 was out of the facility on home visit and later discharged, and is therefore not now included in the total of living center's identified elopement risk residents. *See additional information #1 pg 10 #2- Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Current residents in facility were reassessed on 12/3/10 for potential for Risk for Elopement and no additional residents were identified Risk for Elopement. The facility	

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F 323	Continued From page 3 The LPN stated she was not certain when she last observed Resident #1 on 11/19/10. The LPN assessed Resident #1 upon his/her return to the facility, and found no physical problems. She stated Resident #1 was unable to state where he/she had been going or what he/she had been doing. The LPN did not hear an alarm sound prior to Resident #1 being returned to the facility. Interview with one of the Paramedics who found Resident #1 outside of the facility, on 12/01/10 at 9:35 AM, revealed the Paramedic returned the resident to the facility on 11/19/10, after observing him/her outside the facility, toward the back of the parking lot in a Merri-Walker. The Paramedic stated Resident #1 did not appear to be in any distress. The Paramedic continued that no alarms were sounding as they approached the door to the facility, but the alarm sounded when Resident #1 entered the facility through the front door. According to the Paramedic, the resident was returned to the facility at 5:30 PM. Interview with the Director of Nursing (DON), on 12/01/10 at 9:00 AM, revealed no explanation as to how Resident #1 was able to exit the facility, or why the alarm did not sound on the door. The DON stated the resident had exited the facility at dusk, and the temperature outside was forty-eight (48) degrees when the resident exited. According to the DON, Resident #1 was placed on every fifteen (15) minute checks when he/she returned to the facility. She stated she checked Resident #1's elopement bracelet, as well as, the front door, and determined both to be functioning. When asked about the every fifteen (15) minutes checks, the DON stated she thought the checks were an appropriate intervention, and the resident's family had agreed to the intervention.	F 323	currently has 11 residents at Risk for Elopement (#1, #2, #3, #5, #7, #8, #9, #10, #11, #13, #14). (Please note that #12 was out of the facility on home visit and later discharged, and is therefore not now included in the total.) Audits were conducted by the Director of Nursing Services on 11/20/10 for the 11 residents identified at Risk for Elopement (#1, #2, #3, #5, #7, #8, #9, #10, #11, #13, #14) with review of the following data: Review of the Elopement Risk Assessments for current residents for accuracy of assessment, Secure Care bracelets for expiration utilizing the transmitter and no issues were identified, with all functioning properly. The Certified Nursing Assistant care sheets were reviewed by the Director of Nursing Services on 11/20/10 for identification of Risk for Elopement and that the wander risk stickers were in place on care sheets. No identified issues were found. Documentation records were reviewed by the Director of Nursing Services on 11/20/10 to validate monitoring of secure care checks completed twice a day; one time, during each twelve hour shift. This is an on-going practice to validate monitoring is completed monthly by the Director of Nursing/Assistant Director of Nursing/Charge Nurse. Care Plans reviewed and revised as needed by the Director of Nursing Services on 11/20/10 for current conditions/interventions related to Risk for Elopement.	

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F 323	Continued From page 4 Interview with the Maintenance Supervisor (MS), on 12/02/10 at 11:35 AM, revealed he placed a call requesting inspection of the front door alarm system on 11/22/10, the first business day following the elopement. He continued that he placed a second call on 11/24/10, a third call on 11/29/10, and a fourth call on 12/01/10. He stated no additional interventions were implemented to ensure wandering residents did not exit the front door. Observation on 12/01/10 revealed six (6) exit doors would have been accessible to Resident #1, including three (3) fire doors at the back of the facility, one (1) fire door on each side of the facility, and the front door. All six (6) doors had keypads for exiting without triggering an alarm. Additionally, the front door had an elopement safety system in place that would both temporarily lock and alarm whenever an elopement safety device reached the door. The three (3) back fire doors all led to a long flight of stairs that exited at the back parking lot. One (1) side door led to a steep grassy area that merged into someone's back yard. The other side door led to the front parking lot. The front door led to the front parking lot. All doors were checked in the morning and afternoon of 12/01/10 and were found to alarm as appropriate. The front door was checked against an elopement safety bracelet and alarmed when approached. Additionally, on 12/01/10, staff demonstrated the checks that were made each nursing shift to ensure the functioning of all elopement safety devices. Observation on 12/02/10 from 12:15 PM to 12:30 PM revealed Resident #1 was ambulating using a Merri-Walker from the 200 Unit around an	F 323	The Director of Nursing on 11/20/10 completed a review of the 11 residents currently identified as elopement risk(#1, #2, #3, #5, #7, #8, #9, #10, #11, #13, #14) to determine if additional measures such as 15 minutes visual checks were warranted. Only 1 of the 11 residents was determined to warrant 15 minute visual checks, and this is Resident #1, which had already been implemented. The facility door alarms were checked by the Director of Nursing Services on 11/20/10 with transmitter to ensure functioning appropriately. This door alarm check completed by the Director of Nursing Services is in addition to the routine twice daily check completed by the charge nurses already in place. The Director of Nursing Services on 11/20/10 physically confirmed by opening each exit door that appropriate alarms were sounding. At no time during the audits of the facility alarm system (door checks), completed by the Director of Nursing, Charge Nurses, were there any issues with the alarm system failure. On 11/20/10, the Director of Nursing Services on 11/20/10 checked for current expiration dates of all secure care transmitters, with no issues identified. Documentation in the medication administration record was audited and checked by the Director of Nursing Services on 11/20/10 to validate that secure care bracelets were being monitored by the nursing staff twice daily as well as conducting the performed individual visual checks. On 11/20/10- In-service education begins and is 100% compliant on 12/03/10 with	

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F 323	Continued From page 5 adjoining hall to the 300 Unit where he/she stopped at a fire door and looked out. Resident #1 was initially standing and propelling the Merri-Walker, then sat down upon reaching the fire door. Resident #1 was observed as having a second elopement safety bracelet on the leg of his/her Merri-Walker. Resident #1 ambulated at a steady pace. Observations over the course of the investigation, from 8 AM to 6 PM, revealed Resident #1 to be active wandering throughout the facility. After reviewing the "Verification of Investigation Report" dated 11/19/10, and an investigation summary dated 11/24/10, an observation revealed that, following the route outlined in the report, Resident #1 would have traveled through part of the front parking lot, down a side street with a roughly thirty (30) degree slope, turning left into the facility's back parking lot, traveling through the back parking lot to end in the grassy area beyond, near a highway. ********** An acceptable Allegation of Compliance (AOC) was received on 12/07/10. Review of inservice records revealed on 11/20/10 the DON conducted an Elopement Risk Inservice, providing handouts to all staff outlining the facility's Clinical Guide: Elopement; as well as a handout of a power point presentation. On 11/24/10, a second Elopement Inservice was held with a stronger focus on prevention and awareness. A third Elopement Inservice conducted on 12/02/10 stressed the importance of security in terms of not sharing the door codes.	F 323	employees of all disciplines, including housekeeping, laundry, therapy, dietary, maintenance, and business office was conducted by the Director of Nursing regarding identification of Elopement Risk. The living center does not use agency/registry staffing. * See additional #2 info page 10 #3- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The facility has the following monitoring/tracking system in place in regards to elopement: Group 4 Day Shift nurse and Group 3 Night Shift nurse conducts door safety checks every 12-hour shift by checking door alarms when opened utilizing the system hand-held transmitter to validate door locks and alarms appropriately. Monitoring daily by the Director of Nursing/Assistant Director of Nursing of Medication Administration Record, which documentation is required whereby the nurse documents that the secure bracelet is present on the resident and has not reached its expiration date. As part of the maintenance supervisor's daily rounding process of the facility, which serves as an additional backup, to the established process of the charge nurses monitoring every shift, doors are checked for appropriate locking and alarming with the secure bracelet. New admissions and readmissions are reviewed by the charge nurse for risk of elopement during the admission assessment, and the interdisciplinary team which consists of but not limited to the Director of Nursing Services, Resident Assessment	

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F 323	Continued From page 6 Observation on 12/06/10 at 4:00 PM revealed signs posted on all exits indicating visitors should see staff for assistance with the doors, and also that visitors should not assist any resident seeking exit without staff notification or assistance. The MS stated, in an interview on 12/07/10 at 1:45 PM, that door codes had been changed on 12/02/10. He stated the door codes would be changed quarterly. An interview with the Executive Director (ED) on 12/06/10 at 4:30 PM revealed he had assigned staff to continuously monitor the front door on 12/02/10, after Immediate Jeopardy had been identified. The ED stated staff monitoring of the front door to ensure no further elopement would continue until additional corrective action was taken. Review of the facility's Front Door Checks revealed staff were recording monitoring of the front door from 12/02/10 forward. Interviews with staff members on 12/07/10 from 3:00 PM to 5:30 PM (RN #1, RN #2, Dietary manager (DM), CNA #13, CNA #14) revealed staff were knowledgeable about facility elopement policy, including the need to not give out door codes, which had been changed, and to respond quickly to alarms. Staff were aware the front door was being continuously monitored, beginning 12/02/10. Staff were knowledgeable about which residents on their units were at risk for elopement, and were knowledgeable of the location of the Missing Resident Profile book on the 200 Unit. The Immediate Jeopardy was determined to be removed on 12/03/10. Noncompliance continued	F 323	**Coordinator, Dining Service Manager, Social Services Director and Activity Director complete a second review within 24-72 hours to assure accuracy and completion on scheduled weekday meetings. The Manager of the Day will complete these reviews on Saturday and Sundays as needed.** **The elopement risk assessments are completed/reviewed monthly by the interdisciplinary team for any changes.** **If a resident is determined to be at risk for elopement based on the assessment, the following actions are implemented with documentation by the care team at that time:** ***Missing Resident Profile with picture that is maintained at the central nurses station** ***Immediate Plan of Care completed** ***Order for Secure Care Bracelet check every shift on Medication Administration Record under alarm code** ***Identification bracelet** ***15 minute checks for 72 hours** ***Care plan interventions and family made aware of risk** ***A copy of the missing resident profile placed into the elopement risk book, along with Immediate Plan of Care and a copy of the resident's face sheet** **On 11/20/10- In-service education begins and is 100% compliant on 12/03/10 with employees of all disciplines, including housekeeping, laundry, therapy, dietary, maintenance, and business office was conducted by the Director of Nursing regarding identification of Elopement Risk.** **The living center does not use**	

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F 323	Continued From page 7 with the scope and severity lowered to a "D" based on the facility's need to evaluate the effectiveness of quality assurance activities related to elopement.	F 323	agency/registry staffing. Education of elopement protocol has been added to orientation for newly hired staff. Monthly Elopement Drills will continue to be conducted by the Director of Nursing Services/Assistant Director of Nursing Services/Charge Nurse on alternating shifts. *(See additional #3 page 10)* **#4- Indicate how the facility plans to monitor its performance to ensure that solutions are sustained:** 12/2/10- Signs were posted at entrance doors by Director of Nursing Service that stated to not assist residents outside without checking with nursing staff. These signs will remain at the entrance doors to alert visitors/staff of residents at entrance/exit doors. On 12/02/10, letters were drafted at this time by the Senior Executive Director to mail to families, volunteers and vendors in regards to our safety practices and to not assist residents outside of the facility without checking with facility staff. On 12/02/10, Maintenance Supervisor changed existing codes on all entrance doors. Changing of the door codes will be monthly on-going and documented with maintenance door checks. The Director of Nursing Services/Assistant Director conducted an in-service to staff regarding not giving out door codes at 4:00pm on 12/02/10. This will be ongoing for new hires and existing staff annually. 12/6/10- The enunciator was installed. The door alarms will continue to be monitored on a daily basis by one of the following: 12-9-10	

F 323 (continued) pg. 9

Nursing/Assistant Director of Nursing/Charge Nurses.

The elopement policy and procedures are a part of the standard new hire orientation education.

Monthly elopement drills are completed by the Director of Nursing Services/Assistant Director of Nursing or designated charge nurse.
The scenario, a list of participants, time, shift, and any identified issues are documented. Drill times are rotated every month to cover day, evening and night shift personnel within the quarter. The most recent elopement drill was held on November 30, 2010 at 1:45pm, with no identified issues that warranted further education with staff.

A monthly elopement review will continue to be completed by the Director of Nursing Service/Assistant Director of Nursing/charge nurse to identify any issues with the status of elopement risk residents. The most recent monthly elopement review was completed on 11/30/10 with follow-up to the incident on 11/19/10 with no other issues identified.

On 11/20/10, an ad hoc Quality Assurance and Assessment meeting was initiated with the Director of Nursing, Executive Director, Medical Director and 2 charge nurses to address action items for follow-up on the elopement event.
A Quality Assessment and Assurance Quarterly Elopement Review is completed by the Director of Nursing Services/Assistant Director of Nursing.
As part of the facility Quality Assessment and Assurance, the Executive Director administers oversight to the reviews and audits completed by the Director of Nursing Services. The most recent QA &A meeting was held on 11/26/10, with the Executive Director, Director of Nursing, Dining Service Manager, Activity Director, Assistant Director of Nursing, Medical Records Supervisor, Restorative Nurse and Human Resource Manager and information from the 11/20/10 QA&A ad hoc meeting was brought forward. On-going monitoring of the elopement action plan is to be in place for next 3 consecutive months. This consist of the following: Elopement Risk Assessments, Certified Nursing Assistance care sheets for the wander stickers, Documentation records to validate door alarm checks, and Secure Care Bracelet checks for functioning, and any potential training/education needs related to the Elopement Drills. The next QA&A meeting scheduled for December 23, 2010.

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#2- In addition to the daily observation rounding by the Executive Director, and Director of Nursing, the facility Executive Director assigns a department manager, and/or a nurse to complete a Weekly Non-Clinical Rounds form for six resident rooms which could be up to twelve residents depending upon Census, of the environment to include but not limited to, observation of potential accident hazards, and use of assistive devices. See attached Non-Clinical Rounds form. Opportunities noted during daily observation rounding will be reported to the Executive Director at that time. Once the Weekly Non-Clinical Round form is completed it is then given to the Executive Director for follow up of any opportunities noted for corrective measures.

#3- The facility has added the Non Clinical Rounds form to be completed weekly as indicated above as their systematic changes as preventative measures for accident/hazards. This was initiated on 12/5/10 and 12/8/10 ongoing.

#4= The Executive Director will review the weekly Non-Clinical Round Forms and any opportunities noted will be taken to monthly QA&A and Action Plans will be developed as needed.